Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR WILLIAM L SMITH
2825 IH 10 EAST SUITE 112
BEAUMONT TX 77702

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-1871-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sent HICFA and Report to the insurance adjuster 'Lois Johnson' on **01/05/2011**…sent a final notice before forwarding to TDI to the insurance adjuster on **12/12/2011**…Final notice sent to the insurance adjuster on **12/12/2011**. Told adjuster that the bill is still outstanding and has not been paid…amended HICFA sent to the adjuster in final notice on **12/12/2011**."

Amount in Dispute: $1,125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Requestor has billed for services which were not performed and are not reimbursable. Requestor also billed for psychological testing under CPT code 96116. However, psych was not part of the Claimant's injury or complaints; thus, this testing was unnecessary and should not be reimbursed. It should also be noted that the Requestor did not timely submit their request for reconsideration within 11 months of the date of service as the date of service was 12/27/10, and the reconsideration was submitted until 12/12/11."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2010	99456-NM, 99456-W8, 99456-W5, 96116	$1,125.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. Copies of the explanation of benefits were not submitted by either party for review.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is December 27, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on January 30, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.